STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G022	A. BUILDING _____ B. WING _____	09/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	1026 8TH STREET NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from September 16, 2009 through September 18, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of six men with various disabilities. A focused review of another (fourth) client's meal observation was conducted as well. The findings of the survey were based on observations, interviews with staff and clients in the home and at three day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 10/27/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that outside services met the needs of each client, for one of the three clients (Client #1) included in the sample, to include one focus client. (Client #4) The findings include: 1. The day program failed to ensure staff implemented Client #1's feeding protocol as recommended. On September 17, 2009, beginning at 12:05 p.m., Client #1 was served broccoli, ground beef, and noodles in a high sided plate during lunch time. As Client #1 began to consume his food, he	W 120	Resident # 1's eating protocol was revised on 7-30-09 and the same was provided to the day program on 8-12-09. Q.M.R.P met the lead counselor for resident # 1 @the Day Program and discussed the revised feeding protocol and Adaptive Equipment on 8/13/09. Q.M.R.P also informed The Day Program Director as the Case Manager was not available. Service Coordinator of D.D.S was also informed of the same. It should be noted that at the time of Resident # 1's ISP on 8/3/09 the day program case manager was present and attended the meeting where the Residents objectives and protocols were discussed. On 8-12-09 complete ISP package was given to the Day Program. (contd)	8-12-09 8-13-09 9-18-09 9-21-09 9-25-09 10-20-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Mamta Tiwari | Deputy Director, DOH | 10/26/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 received verbal prompts to slow his eating pace between each spoonful by the day program staff. At 12:07 p.m., staff was observed to place her hand on top of Client #1's hand to guide his spoon to his plate to slow down his eating pace. At 12:10 p.m. to 12:12 p.m., staff provided limited supervision while Client #1 consumed rest of his meal slowly. During this time, Client #1 ate his fruit cup and was observed to take a peer fruit cup before staff could retrieve it. At 12:15 p.m., Client made another attempt to take another peer's fruit cup, but staff intervened. Interview with the day program's area manager and the day program's staff after the lunch meal at approximately 12:25 p.m. revealed Client #1 was at risk for aspiration required several verbal prompts to slow his eating pace. Further interview with area and staff revealed the intervention to verbally prompt Client #1 between each bite was implemented in his feeding protocol dated April 2008. When asked if they had the most current feeding protocol, the area manager stated that she could only recall the feeding protocol dated April 2009. Review of Client #1's current feeding protocol dated July 30, 2009 was reviewed after the dinner meal on September 16, 2009, at approximately 7:25 p.m. The feeding protocol outlined the following: a. Client #1 requires supervision during all meals and snacks. He is independent with eating after set-up. b. Since Client #1 usually waits until the end of his meal to drink his liquids, it is recommended that the client receive his meal in two portions. Staff	W 120	However, on 9/18/09 an in-service was conducted by Q.M.R.P at the Day Program for the Day Program Staff for proper implementation of Resident's protocols . Another training was conducted on 9/21/09 Q.M.R.P made meal time observation for entire week from 9/21/09 until 9/25/09. Another observation was made on 10/20/09. Q.M.R.P will continue to visit day program on monthly basis to monitor and ensure that individuals programs and are properly followed through. See Attachment (E1-E10)	

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W 120	Continued From page 2 should encourage his to sip liquids frequently. c. Monitor closely for signs/symptoms of aspiration. d. Staff may need to physically remove his plate for a few seconds to decrease his rate of eating. When shared with the day program area manager and staff, they both acknowledge that they were not made aware of the interventions to get Client #1 to slow his eating pace. The area manager stated that the qualified mental retardation professional provided training on Client #1's new plate riser in August 2009 but never discussed his feeding protocol. It should be noted that on September 18, 2009, Client #1's day program staff received an in service training on the proper implementation of the client's current feeding protocol. 2. The day program failed to complete a red flag form and failed notify the behavior specialist and/or psychologist staff for consultation immediately when Client #1's target behavior of food stealing resurfaced. Observation of the lunch meal at the day program on September 17, 2009, from 12:10 p.m. to 12:12 p.m. revealed the day program staff provided limited supervision while Client #1 consumed his lunch meal. During this time, Client #1 ate his fruit cup and was observed to take a peer fruit cup before staff could retrieve it. At 12:15 p.m., Client made another attempt to take another peer's fruit cup, but staff intervened. Interview with the day program staff revealed that Client #1 has a behavior of stealing food. The day program	W 120	2. Residential Behavior support plan was resubmitted to the Day Program on 9/21/09 which is being currently used. Day Program Case Manager conveyed all the relevant information to the Day Program Psychologist. Q.M.R.P also spoke to the psychologist and was made aware of the issues. Q. M. R. P visited the Day Program every day between 9/21- 9/25/09 to ensure the implementation of B.S.P @ meal time and also revisited the Day Program on 10/20/09 to monitor the above. Baseline data is being collected at the Day Program. See attachment (F1 and also E8, E10)	

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W 120	Continued From page 3 staff further revealed that Client #1 make attempts to steal food at least 3 to 4 times a week. Interview with the day program's Case Manager (CM) on September 18, 2009, at 9:00 a.m., revealed that Client #1's BSP was discontinued due to significant decrease in his behavior of food stealing. Further interview revealed that if the client's behavior of food stealing resurface, staff would document the behavior on ABC data sheets. Review of the day program's behavior support plan (BSP), discontinued in October 2006, was reviewed on September 18, 2009, at approximately 9:10 a.m. The BSP confirmed the day program staff's interview of taking others' food as a target behavior. Further review of the BSP revealed "should his behavior change in anyway (i.e., intensity, type of behavior, etc.,) staff should complete a Red Flag Sheet and notify the behavior support manager, the behavior specialist, and/or psychologist for consultation immediately." 3. The day program failed to ensure staff implemented Client #4's feeding protocol as recommended. Client #4 was observed at day program On September 17, 2009, at approximately 1:00 p.m., eating a mechanical soft lunch which consisted of ground turkey, mashed potatoes, spinach, apple sauce, water and milk. Client #4's lunch was served in one portion. Interview with day program Staff #1 on the same day at approximately 1:25 p.m., revealed that	W 120	3. On 8/13/09, Day Program was provided with revised new Protocols along with the ISP Package with goals and objectives. On 08/13/09 day program staff was given in-service training by Day Program L.P.N. However yet another in-service training was conducted by the Q.M.R.P at the Day Program on 9/18/09 for the proper implementation of the resident #4's meal protocols. The Day Program is implementing the protocol as Outlined. Q.M.R.P conducted monitoring visits on 09/25/09, 10/05/09, 10/15/09 and 10/20/09. Q.M.R.P will continue to visit and monitor the implementation of protocols on weekly basis x4 and after that on monthly basis. Meal time observation data is developed which will be used for the purpose of monitoring. See Attachment (B1-B7)	9/18/09 9/25/09 10/5/09 10/15/09 10/20/09

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W 120	Continued From page 4 Client #4 was on a mechanical soft diet. Further interview revealed that Client #4's turkey was ground in texture and he received his lunch meal in one portion. When the surveyor made mention of Client #4's lunch should be served in three portions, day program staff stated that he did not get his lunch meal in three portions. Day program Staff #1 further stated she would check the client's records for clarity. Review of the eating and feeding protocol dated July 30, 2009, on September 17, 2009, at 9:30 a.m., revealed that Client #4 was on a chopped diet and his meals should have been separated into three portions to slow his rapid eating pace.	W 120		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for one of three clients included in the sample. (Client #1) The finding includes: 1. Cross refer to W189. The QMRP failed to ensure the facility staff implemented Client #1's feeding protocol during dinner time. 2. Cross refer to W120.1 The QMRP failed to	W 159		

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W 159	Continued From page 5 ensure that the day program staff was implementing Client #1's current feeding protocol. 3. Cross refer to W120.3 The QMRP failed to ensure that the day program staff was implementing Client #3's current feeding protocol. 4. Cross refer to W252. The QMRP failed to ensure facility documented behaviors on the data collection sheets in accordance with the behavior support plans.	W 159	1, 2, 3, 4 Q.M.R.P was provided additional training on 10/02/09 by Program Manager to ensure implementation of protocols, policy procedure and coordination with outside services also to monitor objective and protocols with day program. See attachment (G1)	10-2-09
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for two of four clients residing in the facility. (Clients #1 and #4) The finding includes: 1. The facility failed to effectively implement Client #1's feeding protocol as recommended. On September 16, 2009, at 4:33 p.m., Client #1 was observed eating chopped peeled oranges with a spoon from a bowl at a fast pace. Client #1 refused to slow down when asked by the house manager (HM). The HM was observed to hold	W 189	1& 2 Staff and the House Manager were provided additional training on 9/16/09, 9/21/09 by Q.M.R.P and on 9/25/09 and 10/18/09 by the speech pathologist .To ensure proper implementation of resident #1 & 4's. Eating Protocols. Q.M.R.P will continue to provide training on ongoing basis and also monitoring on a weekly basis until every staff follows program properly and correctly. See Attachment (C1-C6) 1	9-16-09 9-21-09 9-25-09 10-18-09

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W 189	Continued From page 6 Client #1's hand in order to get him to slow his eating pace. Client #1 continued to refuse and used his other hand feed himself. At 4:36 p.m., Client #1 was observed to eat his oranges without verbal and/or physical prompting to slow down his eating pace. Interview with Staff #3 on the same day approximately 5:16 p.m., revealed that he was assigned to Client #1 during snack and dinner time. Staff #3 stated that when Client #1 is eating rapidly, or refusing to slow down, staff should ask him to drop his spoon and/or remove his plate. Interview with the HM on the same day at approximately 5:20 p.m., revealed that she was new to the facility and was still learning the clients'. When asked by the surveyor on how to slow Client #1's eating pace, the HM stated that she should hold his hand for a second. Further interview with the HM revealed that she had received some training on Client #1's feeding protocol prior to working at the facility in June 2009. Review of Client #1's current feeding protocol dated July 30, 2009 was reviewed after the dinner meal on September 16, 2009, at approximately 7:25 p.m. The feeding protocol revealed that in order to get Client #1 to slow his eating pace, "staff may need to physically remove his plate for a few seconds to decrease his rate of eating." On September 18, 2009, at approximately 1:10 p.m., review of the in-service training records revealed that all staff had received training on Client #1's feeding protocol on May 2, 2009. At the time of the survey, there was no evidence that training was effective.	W 189		

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W 189	Continued From page 7 It should be noted that on September 16, 2009, the Qualified Mental Retardation Professional (QMRP) provided an in-service training on the proper implementation of the Client #1's current feeding protocol for all staff during the second shift including the HM. 2. The facility failed to effectively implement Client #4's feeding protocol as recommended. During snack time on September 16, 2009, at 4:31 p.m., Client #4 was observed eating pineapples at a fast pace. At 4:32 p.m., Staff #1 stated "chew chew swallow" as Client # 4 was drinking the remaining juice from the pineapples. During the dinner meal approximately 6:55 p.m., Client # 4 was observed eating a chopped diet with a teaspoon. At 6:59 p.m., Client #4 was observed to eat more than three bites of food before drinking his beverage independently. At 7:04 p.m., Client #4 received a second portion of food and was observed to take six bites of food before drinking his water independently. Client #4 was also observed to pocket food into his mouth and was verbally prompted by Staff #1 to swallow the food in his mouth after the client had taken one additional spoonful. Staff was not observed throughout the dinner meal to encourage Client #4 to use his napkin. Staff #1 was inconsistent in providing verbal prompting during meals by saying "chew chew swallow" and "drink your water". The meal consisted of a tuna sandwich, potatoes, spinach, bean soup, yogurt, milkshake and water. Review of the eating and feeding protocol dated July 30, 2009, on September 17, 2009, at 9:30 a.m., revealed the protocol required the following	W 189		

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W 189	Continued From page 8 techniques and procedures to be implemented: - The staff should prompt him to alternate his liquids and solids. - After two to three bites of food staff should prompt him to take a long drink. - Staff should prompt the client to swallow his food in his mouth before receiving his next portion. - Staff should provide the client with verbal prompts to "rest your spoon" or "put your spoon down". - Staff should encourage the client to use napkins; - Staff should provide the client with verbal prompts to thoroughly chew his food before swallowing by saying "chew chew swallow". Interview with the qualified mental retardation professional on September 17, 2009, at approximately 2:30 p.m., confirmed that the Staff #1 failed to consistently follow Client #4's eating protocol. On September 18, 2009, at approximately 1:00 p.m., review of the in service training records revealed that Staff #1 was trained on Client #4's feeding protocol on May 2, 2009. At the time of the survey, there was no evidence that training was effective.	W 189		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan	W 252		

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W 252	Continued From page 9 objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to document behavior data in accordance with the behavior support plans (BSP), for one of the three clients in the sample. (Client #2) The finding includes: On September 16, 2009, at 5:35 p.m., Client #2 was observed to bite his hand while yelling out when asked to engage in an activity several times by staff. On September 17, 2009, at 3:20 p.m., Client #2 was observed again yelling out and biting his hand while running from the living room area through the dining to the kitchen. Interview with direct care staff on September 17, 2009, at approximately 4:10 p.m., revealed that Client #2 exhibited maladaptive behaviors of yelling and biting his hand when he did not want to participate in activities. Further interview with the direct care staff revealed that yelling and biting hands were his target behaviors. On September 17, 2009, at 12:10 p.m., review of Client #2's BSP dated February 10, 2009, confirmed that yelling and biting his hands were two of his targeted behaviors. The BSP further revealed staff was to record target behaviors on the data collection sheets on every shift, every day. Review of the behavior data collection sheets, however, revealed that staff had not documented Client #2's maladaptive behavior on	W 252	Staff made a mistake by not documenting the behavior when it happened but it was documented in front of the surveyor on 09/18/09. Staff was provided in-service training on ABC of documentation by the Psychologist on 8-18-09 and 9-22-09. Q.M.R.P will continue to provide on going training to staff to ensure proper documentation of behavior and monitor the program closely. See attachment (H1)	8-18-09 9-18-09 9-22-09

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W 252	Continued From page 10 September 16 and 17, 2009. In a follow-up interview with the QMRP on September 18, 2009, at approximately 1:30 p.m., she acknowledged that staff had not documented the yelling and biting his hand as required. There was no evidence that the data had been collected in accordance with the BSP.	W 252		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security for six of six clients in the facility. (Client # 1, Client #2, Client #3, Client # 4, Client # 5 and Client #6) The finding includes: On September 16, 2009 at approximately 5:46 p.m., Licensed Practical Nurse #1 (LPN#1) was observed to lock the medication closet door, leaving the medication keys in the padlock. Further observation revealed LPN #1 then left the open medication room to escort Client # 3 upstairs to the first level of the facility. In an interview with LPN#1 on September 16, 2009 at approximately 6:00 p.m., it was acknowledged the medication keys were left in the medication padlock when he left the open medication room. There was no evidence that all drugs were stored under proper conditions of security.	W 381	L.P.N was given training on 10/02/09 by the R.N. On policy of medication administration and Infection control. R.N will continue to provide on going training and unannounced medication administration monitoring. See attachment (D1-D7)	10-2-09
W 455	483.470(l)(1) INFECTION CONTROL	W 455		

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W 455	Continued From page 11 There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for six of six clients residing at the home. (Clients #1, #2, #3, #4, #5 and Client #6) The findings include: 1. During medication administration observation on September 16, 2009, at approximately 5:20 p.m., licensed practical nurse #1 (LPN #1) was observed to wash his hands with soap and water prior to administering medications. Further observation revealed LPN #1 used hand sanitizer to cleanse his hands prior to administrating medications to Client #2. However, LPN #1 touched the Medication Administration Records (MAR's) and then touched the rim of the medication cup Client #2 used for self-medication. In an interview with LPN #1 on September 16, 2009, at approximately 6:10 p.m., it was acknowledged after using hand sanitizer to cleanse his hands, he touched the MAR's and then touched the rim of the medication cup Client #2 used for self-medication. There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	W 455	1. L.P.N was given training on 10/02/09 by the R.N. On policy of medication administration and Infection control. R.N. will continue to provide on going training unannounced during medication administration monitoring. See attachment (D1-D7)	10-2-09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G022	A. BUILDING _____ B. WING _____	09/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	1026 8TH STREET NE WASHINGTON, DC 20002

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W 455	Continued From page 12 2. During medication administration observation on September 16, 2009, at approximately 5:35 p.m., LPN #1 used hand sanitizer to cleanse his hands prior to administrating medications to Client #3. However LPN #1 touched the medication MAR's, the table and than touched the rim of the medication cup as he administered Client #3's medication. In an interview with LPN #1 on September 16, 2009, at approximately 6:10 p.m., it was acknowledged after using hand sanitizer to cleanse his hands he touched the MAR's, the table and than touched the rim of the medication cup as he administered Client #3's medication. There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection. 3. On September 17, 2009, at 11:22 a.m., Client #1 was observed sitting at a round table holding two wooden blocks. At 11:30 a.m., Client #1 placed a different set of blocks into the peg board. At 11:50 a.m., Client #1 was rolling a basketball back/forth with his peers. At 11:55 a.m., Client #1 was observed to pull on the door handles to the main entry door to the class room. At 12:05 p.m., Client #1 was escorted to the cafeteria area for lunch. Approximately one minute later, Client #1 was sitting down eating his lunch which consisted of ground beef, noodles, and broccoli. At 12:10 p.m., Client #1 was observed to eat the rest of his food outside of his plate that spilled on the dycem mat with his hands. The day program who was observed across from Client #1 feeding other clients did not redirect the client to stop eating with his hands.	W 455	2. L.P.N was given training on 10/02/09 by the R.N. On policy of medication administration and Infection control. R.N. will continue to provide on going training and unannounced during medication administration monitoring. See attachment (D1-D7) 3. Q.M.R.P provided general hygiene and infection control training at the Day Program on 10/23/09. Q.M.R.P will continue to follow up with Day Program on implementation of universal precautions for infection control during monthly visits to day program. See attachment (I1-I3)	10-2-09 10-23-09

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W 455	Continued From page 13 Interview with the day program staff at approximately 12:25 p.m., acknowledged that Client #1 did not wash his hands before lunch. The staff stated that it was poor oversight on his part. There was no evidence that proper infection control procedures were implemented before and during lunch time. 4. On September 17, 2009, at 3:20 p.m., Client #2 was observed biting his hand and yelling when asked to participate in an activity by direct care staff. At 3:22 p.m., Client #2 was engaged in making a necklace with various beads located inside a plastic bowl. Approximately one minute later, Client #2 was sitting at the dining room table opening up an Oreo cakester cake in which he consumed. The client was not observed to wash his hands. Interview with the qualified mental retardation professional (QMRP) on the same day at approximately 3:40 p.m. acknowledged that Client #2 did not wash his hands before eating his afternoon snack. There was no evidence that proper infection control procedures were implemented during snack time. 5. On September 16, 2009, at 6:22 p.m., Staff #2 was observed entering the living room as she was putting on plastic gloves. Staff #2 asked Client #2 to assist her with serving dinner. At 6:23 p.m., Staff #2 retrieved the toaster from the top of the deep freezer and plugged it in the socket. Less than a minute later, Staff #2 was observed opening the refrigerator and the deep freezer. At approximately 6:30 p.m. Staff #2 began to measure the food with the same glove.	W 455		
		4& 5	R.N. conducted an in service training on 09/21/09 for infection control Q.M.R.P will continue to ensure that proper infection control procedures are being implemented by doing spot observations ongoing basis. See attachment (J1)	9-21-09

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W 455	Continued From page 14 Interview with the QMRP on September 17, 2009, at approximately 2:00 p.m. confirmed that infection control should be implemented at all times. There was no evidence that proper infection control procedures were implemented while serving dinner.	W 455		
W 472	483.480(b)(2)(i) MEAL SERVICES Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food portions were served in accordance with prescribed diets for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The finding includes: Observation on September 16, 2009, at approximately 6:30 p.m., Staff #2 was observed to use a 1/3 measuring cup to measure spinach and an 8 ounce measuring cup to measure the bean soup for all six clients. Further observation revealed Staff #2 scooped tuna fish with a regular tablespoon and placed it on the bread. Staff #2 was also observed placing whole potatoes on each of the clients' plates without measuring. Review of the spring/summer 2009 menu on September 17, 2009, at approximately 1:00 p.m., revealed Clients #1, #3, #5, and #6 should have received 3 ounces of tuna fish, half cup of spinach, 6 ounces of bean soup and a half cup of boiled potatoes. Interview with Staff #1 on the same day at	W 472	On 8/13/09, Day Program was provided with revised new Protocols along with the ISP Package with goals and objectives. On 08/13/09 day program staff was given in-service training by the Day Program LPN. How ever yet another in-service training was conducted by the Q.M.R.P at the Day Program on 9/18/09 for the proper implementation of the resident #4's meal protocols. The Day Program is implementing the protocol as Outlined. Q.M.R.P conducted monitoring visits on 09/25/09, 10/05/09, 10/15/09 and 10/20/09. Q.M.R.P will continue to visit and monitor the implementation of protocols on weekly basis x4 and after that on monthly basis. Meal time observation data is developed which will be used for the purpose of monitoring. See Attachment (B1-B7)	8-13-09 9-18-09 9-25-09 10-5-09 10-15-09 10-20-09

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W 472	Continued From page 15 approximately 3:45 p.m., confirmed that the tuna fish sandwich and the boiled potatoes required measuring. Further interview with Staff #2 revealed that she was able to verbally state the correct measurements to measure the clients' food. However, when Staff #2 was asked to show the surveyor the 1/2 cup, Staff #2 showed the 1/3 measuring cup. Staff #2 acknowledged that she should have been using the 1/2 cup instead of the 1/3 cup when measuring the clients' food.	W 472		

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 16, 2009 through September 18, 2009. A random sample of three residents was selected from a resident population of six men with various disabilities. A focused review of another (fourth) client's meal observation was conducted as well. The findings of the survey were based on observations, interviews with staff and clients in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.	I 000	Received 10/21/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food portions were served in accordance with prescribed diets for six of six residents residing in the facility. (Resident #1, #2, #3, #4, #5, and #6) The finding includes: Observation on September 16, 2009, at approximately 6:30 p.m., Staff #2 was observed to use a 1/3 measuring cups to measure spinach and an 8 ounce measuring cup to measure the bean soup for all six residents. Further observation revealed Staff #2 scooped tuna fish with a regular tablespoon and placed it on the bread. Staff #2 was also observed placing whole	I 042		

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I 042	Continued From page 1 potatoes on each of the residents' plates without measuring. Review of the spring/summer 2009 menu on September 17, 2009, at approximately 1:00 p.m., revealed Residents #1, #3, #5, and #6 should have received 3 ounces of tuna fish, half cup of spinach, 6 ounces of bean soup and a half cup of boiled potatoes. Interview with Staff #1 on the same day at approximately 3:45 p.m., confirmed that the tuna fish sandwich and the boiled potatoes required measuring. Further interview with Staff #2 revealed that she was able to verbally state the correct measurements to measure the residents' food. However, when Staff #2 was asked to show the surveyor the 1/2 cup, Staff #2 showed the 1/3 measuring cup. Staff #2 acknowledged that she should have been using the 1/2 cup instead of the 1/3 cup when measuring the clients' food. 2. Cross refer to Federal Citation W120. The day program failed to ensure staff implemented Client #4's feeding protocol as recommended.	I 042	1. An in-service training was given by the Nutritionists on 06/08/09, 08/27/09 on Diet, texture and measurement. However additional training was provided on 10/02/09 by the nutritionist. On accurate measurement of food as per diet. Q.M.R.P will monitor staff during meal preparation on weekly basis x4 then on a monthly basis and whenever present in facility at meal time. See Attachment (A1-A4)	6/8/09 8/27/09 10/2/09
		1042	2. On 8/13/09, Day Program was provided with revised new Protocols along with the ISP Package with goals and objectives. On 08/13/09 day program staff was given in-service training by the Day Program LPN. However yet another in-service training was conducted by the Q.M.R.P at the Day Program on 9/18/09 for the proper implementation of the resident #4's meal protocols. The Day Program is implementing the protocol as Outlined Q.M.R.P conducted monitoring visits on 09/25/09, 10/05/09, 10/15/09 and 10/20/09. Q.M.R.P will continue to visit and monitor the implementation of protocols on weekly basis x4 and after that on monthly basis. Meal time observation data is developed which will be used for the purpose of monitoring. See Attachment (B1-B7)	8/13/09 9/18/09 9/25/09 10/5/09 10/15/09 10/20/09
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that residents received their meals as outlined in their dietary	I 047		

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I 047	Continued From page 2 plan for one of four residents residing in the facility. (Resident #4) The finding includes: Resident #4 was observed at day program On September 17, 2009, at approximately 1:00 p.m., eating a mechanical soft lunch which consisted of ground turkey, mashed potatoes, spinach, apple sauce, water and milk. Resident #4's lunch was served in one portion. Interview with day program Staff #1 on the same day at approximately 1:25 p.m., revealed that Resident #4 was on a mechanical soft diet. Further interview revealed that Resident #4's turkey was ground in texture and he received his lunch meal in one portion. When the surveyor made mention of Resident #4's lunch should be served in three portions, day program staff stated that he did not get his lunch meal in three portions. Day program Staff #1 further stated she would check the resident's records for clarity. Review of the eating and feeding protocol dated July 30, 2009, on September 17, 2009, at 9:30 a.m., revealed that Resident #4 was on a chopped diet and his meals should have been separated into three portions to slow his rapid eating pace. At the time of the survey, the day program failed to ensure staff implemented Resident #4's feeding protocol as recommended.	I 047	On 8/13/09, Day Program was provided with revised new Protocols along with the ISP Package with goals and objectives. On 08/13/09 day program staff was given in-service training by the Day Program LPN. However yet another in-service was conducted by the Q.M.R.P at the Day Program on 9-18-09 for the proper implementation of the resident #4's meal protocols. The Day Program is implementing the protocol as Outlined. Q.M.R.P conducted monitoring visits on 09/25/09, 10/05/09, 10/15/09 and 10/20/09. Q.M.R.P will continue to visit and monitor the implementation of protocols on weekly basis x4 and after that on monthly basis. Meal time observation data is developed which will be used for the purpose of monitoring. See Attachment (B1-B7) B7.1	8/13/09 9/18/09 9/25/09 10/5/09 10/15/09 10/20/09
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel.	I 222	See Attachment	

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I 222	Continued From page 3 This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for two of four clients residing in the facility. (Residents #1 and #4) The finding includes: 1. The facility failed to effectively implement Resident #1's feeding protocol as recommended. On September 16, 2009, at 4:33 p.m., Resident #1 was observed eating chopped peeled oranges with a spoon from a bowl at a fast pace. Resident #1 refused to slow down when asked by the house manager (HM). The HM was observed to hold Resident #1's hand in order to get him to slow his eating pace. Resident #1 continued to refuse and used his other hand to feed himself. At 4:36 p.m., Resident #1 was observed to eat his oranges without verbal and/or physical prompting to slow down his eating pace. Interview with Staff #3 on the same day approximately 5:16 p.m., revealed that he was assigned to Resident #1 during snack and dinner time. Staff #3 stated that when Resident #1 is eating rapidly, or refusing to slow down, staff should ask him to drop his spoon and/or remove his plate. Interview with the HM on the same day at approximately 5:20 p.m., revealed that she was new to the facility and was still learning the residents'. When asked by the surveyor on how to slow Resident #1's eating pace, the HM stated that she should hold his hand for a second.	I 222	1& 2 Staff and The House Manager were provided additional training on 9/16/09, 9/21/09 by Q.M.R.P and on 9/25/09 and 10/18/09 by the speech pathologist .To ensure proper implementation of resident #1 & 4's Eating Protocols Q.M.R.P will continue to provide training on ongoing basis and also monitoring on a weekly basis until every staff follows program properly and correctly. See Attachment (C1-C6)	9/16/09 9/21/09 9/25/09 10/18/09

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I 222	Continued From page 4 Further interview with the HM revealed that she had received some training on Resident #1's feeding protocol prior to working at the facility in June 2009. Review of Resident #1's current feeding protocol dated July 30, 2009 was reviewed after the dinner meal on September 16, 2009, at approximately 7:25 p.m. The feeding protocol revealed that in order to get Resident #1 to slow his eating pace, "staff may need to physically remove his plate for a few seconds to decrease his rate of eating." On September 18, 2009, at approximately 1:10 p.m., review of the in-service training records revealed that all staff had received training on Resident #1's feeding protocol on May 2, 2009. At the time of the survey, there was no evidence that training was effective. It should be noted that on September 16, 2009, the Qualified Mental Retardation Professional (QMRP) provided an in-service training on the proper implementation of the Resident #1's current feeding protocol for all staff during the second shift including the HM. 2. The facility failed to effectively implement Resident #4's feeding protocol as recommended. During snack time on September 16, 2009, at 4:31 p.m., Resident #4 was observed eating pineapples at a fast pace. At 4:32 p.m., Staff #1 stated "chew chew swallow" as Resident # 4 was drinking the remaining juice from the pineapples. During the dinner meal approximately 6:55 p.m., Resident # 4 was observed eating a chopped diet with a teaspoon. At 6:59 p.m., Resident #4 was observed to eat more than three bites of food before drinking his beverage independently. At	I 222	Staff and The House Manager were provided additional training on 9/16/09, 9/21/09 by Q.M.R.P and on 9/25/09and 10/18/09 by the speech pathologist . To ensure proper implementation of resident #1 & 4's Eating Protocols. Q.M.R.P will continue to provide training on ongoing basis and also monitoring on a weekly basis until every staff follows program properly and correctly. See Attachment (C1-C6), C6.1	9-16-09 9-21-09 9-25-09 10-18-09

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I 222	Continued From page 5 7:04 p.m., Resident #4 received a second portion of food and was observed to take six bites of food before drinking his water independently. Resident #4 was also observed to pocket food into his mouth and was verbally prompted by Staff #1 to swallow the food in his mouth after the resident had taken one additional spoonful. Staff was not observed throughout the dinner meal to encourage Resident #4 to use his napkin. Staff #1 was inconsistent in providing verbal prompting during meals by saying "chew chew swallow" and "drink your water". The meal consisted of a tuna sandwich, potatoes, spinach, bean soup, yogurt, milkshake and water. Review of the eating and feeding protocol dated July 30, 2009, on September 17, 2009, at 9:30 a.m., revealed the protocol required the following techniques and procedures to be implemented: - The staff should prompt him to alternate his liquids and solids. - After two to three bites of food staff should prompt him to take a long drink. - Staff should prompt the resident to swallow his food in his mouth before receiving his next portion. - Staff should provide the client with verbal prompts to "rest your spoon" or "put your spoon down". - Staff should encourage the resident to use napkins; - Staff should provide the resident with verbal prompts to thoroughly chew his food before swallowing by saying "chew chew swallow".	I 222		

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I 222	Continued From page 6 Interview with the qualified mental retardation professional on September 17, 2009, at approximately 2:30 p.m., confirmed that the Staff #1 failed to consistently follow resident #4's eating protocol. On September 18, 2009, at approximately 1:00 p.m., review of the in service training records revealed that Staff #1 was trained on Resident #4's feeding protocol on May 2, 2009. At the time of the survey, there was no evidence that training was effective.	I 222		
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for six of six clients residing at the home. (Clients #1, #2, #3, #4, #5 and Client #6) The findings include: 1. During medication administration observation on September 16, 2009, at approximately 5:20 p.m., licensed practical nurse #1 (LPN #1) was observed to wash his hands with soap and water prior to administrating medications. Further observation revealed LPN #1 used hand sanitizer to cleanse his hands prior to administrating medications to Resident #2. However LPN #1 touched the Medication Administration Records	I 226 1& 2	LPN was given training on medication administration policy and infection control on 10/2/09 by the RN. RN will continue to provide ongoing training and unannounced monitoring during medication administration times. See Attachment (D1-D7)	10/2/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0060	A. BUILDING _____ B. WING _____	09/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	1026 8TH STREET NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 226	Continued From page 7 (MAR's) and than touched the rim of the medication cup Resident #2 used for self-medication. In an interview with LPN #1 on September 16, 2009, at approximately 6:10 p.m., it was acknowledged after using hand sanitizer to cleanse his hands he touched the MAR's and than touched the rim of the medication cup Resident #2 used for self-medication. There is no evidence that the facility's nursing staff demonstrated effective training on infection control. 2. During medication administration observation on September 16, 2009, at approximately 5:35 p.m., LPN #1 used hand sanitizer to cleanse his hands prior to administrating medications to Resident #3. However LPN #1 touched the medication MAR's, the table and than touched the rim of the medication cup as he administered Resident #3's medication. In an interview with LPN #1 on September 16, 2009, at approximately 6:15 p.m., it was acknowledged after using hand sanitizer to cleanse his hands he touched the MAR's, the table and than touched the rim of the medication cup as he administered Resident #3's medication. There is no evidence that the facility's nursing staff demonstrated effective training on infection control.	I 226		